

No Time to Wait

Ensuring a Good Start for Infants and Toddlers in the District of Columbia



A SPECIAL REPORT

by the Task Force On Strategic Planning for Infant and Toddler Development

MAYOR'S ADVISORY COMMITTEE ON EARLY CHILDHOOD DEVELOPMENT

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Executive Summary

The early years are a period of unparalleled growth. From the time of conception to the first day of kindergarten, development proceeds at a pace exceeding that of any subsequent stage in life. Although the early years are a time of great opportunity for young children, they are also a time of great vulnerability. Babies and toddlers need caregivers and parents to be warm and nurturing, as well as to protect them from environmental toxins, extreme poverty, malnutrition, substance abuse, homelessness, child abuse and neglect, community or family violence, and poor quality child care. Early and sustained exposure to such risks can influence the physical architecture of the developing brain, preventing babies and toddlers from fully developing the neural pathways and connections that facilitate later learning.

Every year, close to 8,000[1] new residents are born into the nation's capital, and there are 19,071[2] children younger than age three. They live in a city where the trends on a variety of indicators of well-being for young children are improving.

- The number of children in foster care declined from 3,466 in 1999 to 2,554 in 2005.[3]
- In 2005, the number of families applying for emergency shelter declined for the first time in six years.[4]
- The District of Columbia has one of the highest access rates for children eligible for child care subsidies in the nation. Sixty-eight percent of eligible children received subsidies in 2005, while the national average is estimated to be between 15 percent and 20 percent.[5]

But in one of the most powerful cities in the world, **we are failing our youngest citizens in key areas that will affect their success once they enter school**.

- Close to one-half of the infants and toddlers in the District live in low-income families, and almost one-quarter live in extreme poverty (below 50 percent of the federal poverty level or $8,300 for a family of three).[6]
- Twenty-two percent of children younger than age three in the District are exposed to three or more risk factors – twice the national average.[7]
- More than one-third of all mothers, and more than one-half of Hispanic mothers, did not have adequate prenatal care, which includes beginning prenatal care in their first trimester and making at least nine subsequent visits.[8]
- Fifty-six percent of all births in the District were to single mothers, and in Wards 7 and 8 the rate is 80 percent or more.[9]
- There are an estimated 2,000 at-risk families in the District who could benefit from home visiting services, and less than 30 percent of that group receives them.[10]
- Medicaid reimbursement rates in the District are among the lowest in the country. Nationally, Medicaid reimburses primary care physicians an average of 62 percent of Medicare fees. A Medicaid primary care physician in the District of Columbia receives 35 percent of the Medicare fee for the same service.[11]
- According to the IDEA Infant and Toddler Coordinators Association, the District of Columbia is one of only a few states that do not dedicate any state or local funds for early intervention (IDEA Part C) services.[12]
- Only 4 percent of eligible children (from birth to age three) receive Early Head Start services.[13]
- Of the 348 licensed child care centers in the District, only 149 offer infant care. These centers have the capacity to serve 3,893 children younger than age two, yet there are an estimated 13,000 children younger than age two in the

District. By comparison, 325 of the 348 centers serve children from age three to age five.[14]

- Child care data gathered over a four-year period indicate the quality of child care in many infant/toddler classrooms in the District is inadequate.[15] The Quality Training Assessment Project found that out of twenty-four indicators, almost half were rated "minimal" or "below minimal" for all four years.[16]

To identify ways to help infants and toddlers grow and thrive, the District of Columbia's Mayor's Advisory Committee on Early Childhood Development created the Task Force on Strategic Planning for Infant and Toddler Development. Task force members – representing local home- and center-based child care programs, health clinics, social service agencies, universities, and relevant local government agencies – met twice, and prepared a set of eleven recommendations for the city's leaders framed by the cornerstones of good health, strong families, and positive early learning experiences. Although the depth and breadth of the recommendations reaffirm there is no single or simple solution, three principles should guide future decisions about prioritizing and implementing the task force's recommendations.

Support the development of strong families and nurturing caregivers.
The healthy development of young children depends on the healthy development of the adults in their lives. Families that face economic insecurity, parents who struggle with substance abuse or mental illness, and child care providers who do not have adequate skills or resources cannot provide the nurturing environments that babies and toddlers need to thrive.

Provide comprehensive supports.
Families with babies and toddlers need access to a medical and dental home, high-quality comprehensive child care, home visiting services, and mental health, substance abuse, and other family support services. These families need coordinated access to all these supports, not a piecemeal approach, to protect them from the multiple risks threatening their healthy development.

Target areas of extreme need.
There are concentrated areas of extreme poverty and risk in the District of Columbia. Babies, toddlers, and their caregivers who live in these areas have the most to lose from inaction, and the most to gain from a coordinated, comprehensive response.

With the dramatic growth and development that takes place in the early years, infants and toddlers need the attention of policymakers now.
The task force's recommendations provide a roadmap to guide policymakers in enacting policies supporting good health, strong families, and positive early learning experiences for infants and toddlers in the District of Columbia. District leaders must act now to support families and the developmental needs of their young children before it is too late.

There is no time to wait.

Policy Recommendations in Brief

GOAL I: IMPROVE ACCESS TO HEALTH AND MENTAL HEALTH SERVICES

1. Increase prenatal care, with a focus on Health Professional Shortage Areas.

A. Identify and address barriers to prenatal care.

B. Improve the quality and number of prenatal care facilities in Health Professional Shortage Areas.

2. Support current efforts to improve the developmental screening of children, and increase efforts to ensure children receive the followup evaluations and services they need.

A. Provide core funding for the DC Partnership to Improve Children's Healthcare Quality to continue implementing, validating, and continuously improving the standardized medical record forms.

B. Increase Medicaid reimbursement rates so children receive the followup evaluations and services they need.

3. Help parents bridge the gap between their children's health care needs and the health care system.

A. Examine how Medicaid managed care organizations are conducting outreach to parents.

B. Support the recommendation of the District of Columbia's Children with Special Health Care Needs Advisory Board to create a central service delivery system to provide early identification, diagnosis, and treatment.

C. Raise awareness about the importance of a dental home.

4. Ensure access to mental health services by increasing the organizational commitment and resources of the Department of Mental Health in regard to early childhood development.

A. Appoint an individual in the District's Department of Mental Health to focus solely on early childhood mental health, particularly working to address the mental health needs of very young children.

B. Garner funding to reinstate access to mental health consultation for all early childhood programs.

GOAL II: SUPPORT FAMILIES OF VERY YOUNG CHILDREN

5. Intensify efforts to provide parenting information and support to parents of newborns, infants, and toddlers.

A. Ensure help lines provide responsive assistance and accurate referral information.

- Convene administrators of the District's primary help lines for parents of very young children to establish a schedule for regularly updating information.
- Improve training for staff who answer these help lines to ensure appropriate and responsive assistance.

B. Launch an outreach campaign for parents, particularly fathers, to raise awareness of the importance of the first three years of child development and to connect them to existing information and referral resources.

6. Expand and better coordinate home visiting services to families.

A. Provide core funding for the Home Visiting Council to coordinate existing home visiting programs, provide training and evaluation so programs meet high standards of quality, and ensure families receive appropriate home visiting services.

B. Increase funding for home visiting services.

C. Establish a universal screening and referral process for all District residents who are parents of newborns.

7. Dedicate local funds to provide early intervention services to more infants and toddlers.

GOAL III: PROMOTE POSITIVE EARLY LEARNING EXPERIENCES

8. Create a network of early development programs, and at least two comprehensive service centers, particularly in neighborhoods with poor performing schools and high concentrations of poverty.

A. Develop a network of Early Development Programs building on existing child care providers.

B. Create at least two comprehensive service centers in areas of the city with high concentrations of poverty.

9. Support the professional development of infant and toddler child care providers.

A. Support a career pathway that leads to degrees and/or credentials for infant and toddler caregivers.

- Establish an Associate of Arts (A.A.) degree in Child Development with a concentration in infant and toddler care at a local institution of higher education.
- Increase child care subsidy reimbursement rates to support base pay at the living wage level for caregivers in subsidized programs.
- Increase scholarships for infant and toddler caregivers to earn credentials.
- Promote increased staff compensation linked to professional development and education.

B. Provide training on the birth-to-three early learning guidelines through the Early Childhood Leadership Institute.

C. Develop a network of infant/toddler specialists who provide onsite guidance and support to infant and toddler caregivers on issues related to early development, health, mental health, family support, and program quality.

D. Increase the capacity of child care settings to provide care to families that reflect their culture and language.

GOAL IV: PROVIDE THE RESOURCES AND SUPPORT NECESSARY TO ENSURE THAT CHILDREN GET OFF TO A GOOD START

10. Ensure that funding is available to implement these recommendations.

A. Establish a set-aside of at least 20 percent of any preschool expansion funds to improve infant and toddler care.

B. Increase child care funds targeted at improving infant and toddler care.

C. Expand Early Head Start funds or encourage Congress to permit Head Start funds to be used for children from birth to age five in the District of Columbia.

D. Create a public-private partnership dedicated to funding services for infants and toddlers.

11. Ensure adequate personnel in city government to support programs and services for children and families.

No Time to Wait:

Ensuring a Good Start for Infants and Toddlers in the District of Columbia

Introduction

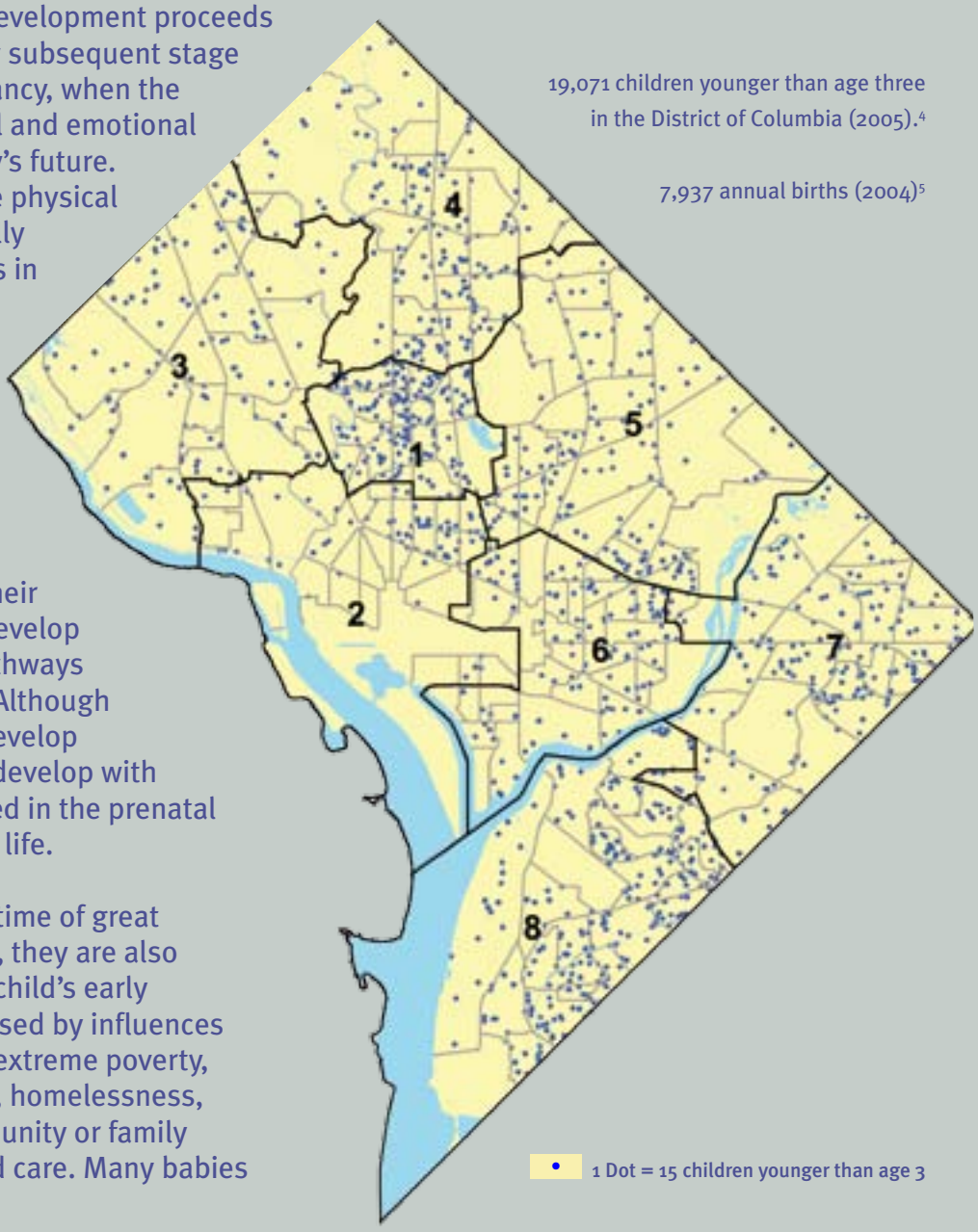
A growing body of research highlights the tremendous and unique window of opportunity to optimize future child development during the first three years of life. These early years are a period of unparalleled growth. From the time of conception to the first day of kindergarten, development proceeds at a pace exceeding that of any subsequent stage in life.[1] It begins during pregnancy, when the mother's nutrition and physical and emotional health begin to shape her baby's future. Early experiences influence the physical architecture of the brain, literally shaping the neural connections in an infant's developing mind.[2] Young children who do not have the opportunity to participate in quality early learning experiences, those who are rarely spoken to, or those who have little opportunity to explore and experiment with their environment may fail to fully develop the neural connections and pathways that facilitate later learning.[3] Although a child's brain takes years to develop completely, never again will it develop with the speed and capacity reflected in the prenatal months and first three years of life.

Although the early years are a time of great opportunity for young children, they are also a time of great vulnerability. A child's early development can be compromised by influences such as environmental toxins, extreme poverty, malnutrition, substance abuse, homelessness, child abuse and neglect, community or family violence, and poor quality child care. Many babies

Population of Children Younger than Age Three in the District of Columbia

19,071 children younger than age three in the District of Columbia (2005).[4]

7,937 annual births (2004)[5]



face significant challenges long before they even learn to talk. Access to comprehensive, high-quality, developmentally appropriate programs and services – whether child care, Early Head Start, early intervention, or home visiting – can serve as a protective factor for infants and toddlers.

In the District of Columbia, the trends on a variety of indicators of well being for young children are improving. But the nation's capital is still falling short in key areas that will affect the **success of young children once they enter school.** It is clear there are concentrated, extreme areas of poverty and risk for infants and toddlers in the District, and we must act now to support families and the developmental needs of their young children.

On March 15, 2006, the District of Columbia's Mayor's Advisory Committee on Early Childhood Development created the Task Force on Strategic Planning for Infant and Toddler Development to identify policy recommendations that would improve services and supports for infants and toddlers. Joan Lombardi chaired the task force with staff support from Barbara Ferguson Kamara and ZERO TO THREE. Task force members – representing local home- and center-based child care programs, health clinics, social service agencies, universities, and relevant local government agencies – met twice, and reviewed two drafts of this report. ***No Time to Wait: Ensuring a Good Start for Infants and Toddlers in the District of Columbia*** is the culmination of the task force's work. It offers eleven policy recommendations organized by four goals:

- improve access to health and mental health services;
- support families of very young children;
- promote positive early learning experiences; and
- provide the resources and support necessary to ensure that children get off to a good start.

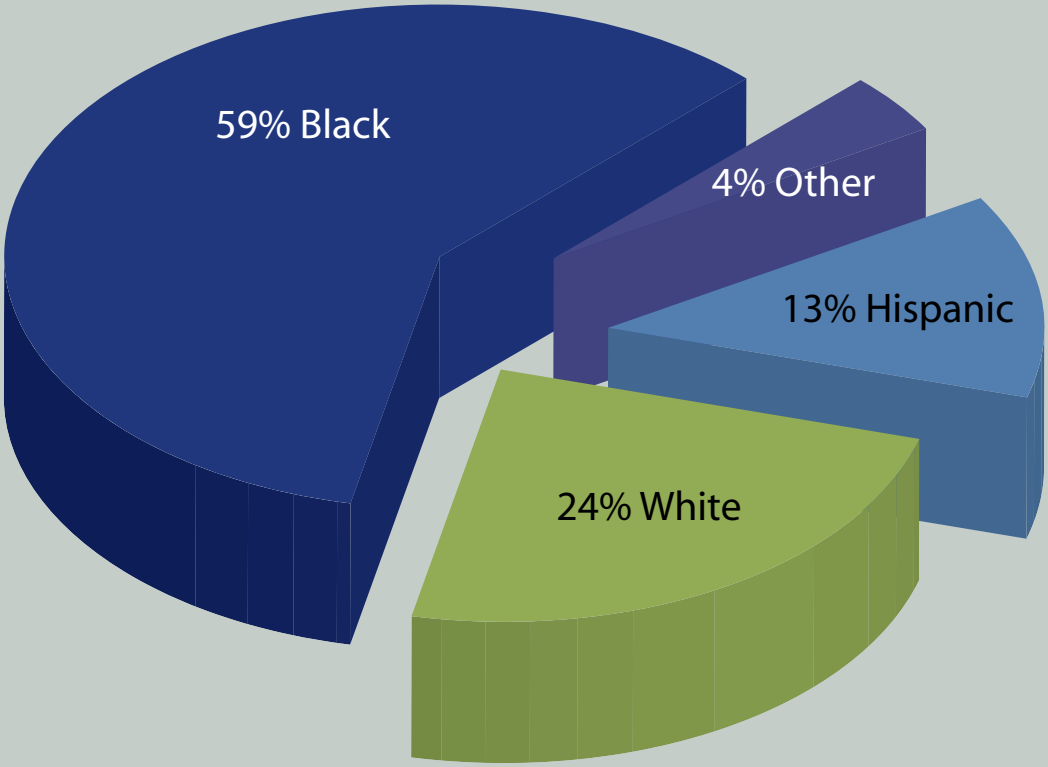
We know, from the data and from experience, that babies cannot wait. With the tremendous growth and development taking place in the early years, infants and toddlers need the attention of policymakers now. We must work to ensure that policies and programs help infants and toddlers get off to the best possible start in life. We have a responsibility to take action now – to guide policymakers in enacting policies that support good health, strong families, and positive early learning experiences for all infants and toddlers in the District of Columbia.

There is no time to wait.

Portrait of Infants and Toddlers in the District:

19,071 children younger than age three in the District of Columbia (2005).[4]
7,937 annual births (2004)[5]

Births, by Race



Source: *Every KID COUNTS in the District of Columbia*, 13th Annual Fact Book, 2006 (data year 2004)

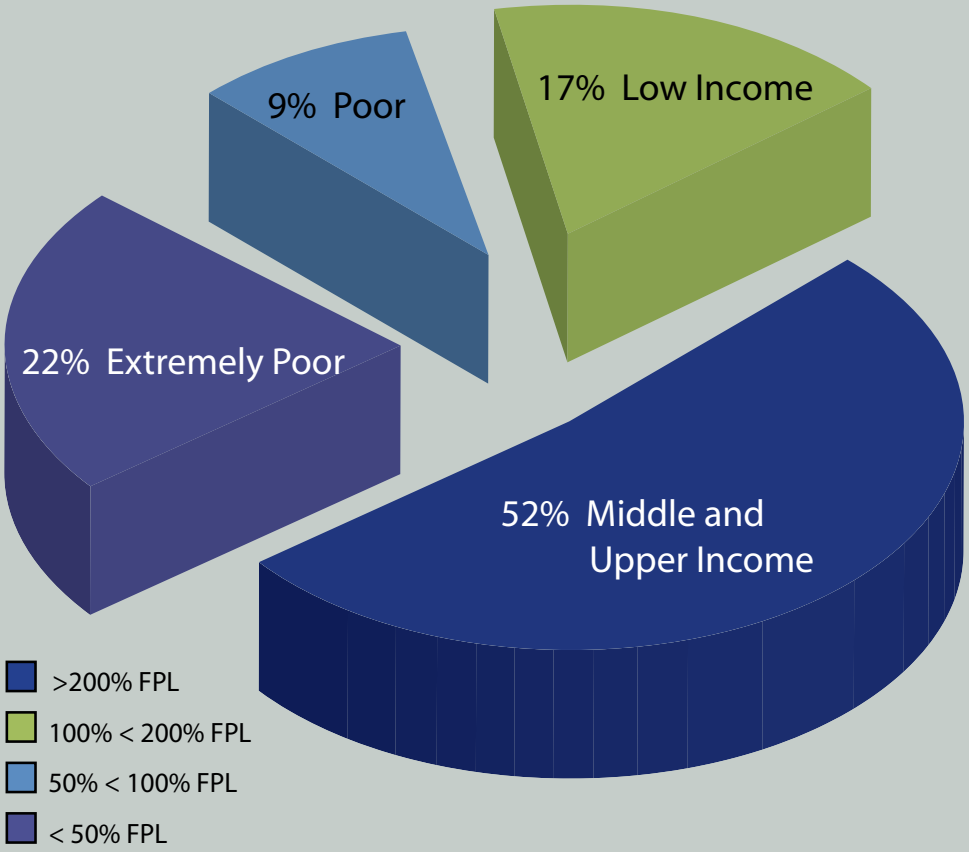
Birth Data, by Ward

	D.C.	Ward 1	Ward 2	Ward 3	Ward4	Ward 5	Ward 6	Ward 7	Ward 8
Births with Adequate Prenatal Care	62%	59%	70%	84%	61%	59%	66%	52%	53%
Births to Single Mothers	56%	54%	30%	8%	49%	66%	50%	83%	80%
Low Birthweight Births	11%	10%	10%	5%	9%	13%	11%	14%	14%

Source: Every KID COUNTS in the District of Columbia; 13th Annual Fact Book 2006 (data year 2004)

Demographic Data

Infants and Toddlers, by Income Level



Note: FPL means federal poverty level

Source: National Center for Children in Poverty using the March supplement of the Current Population Survey for 2003-2005

Proportion of Children Younger than Age Five Living Below the Poverty Level By Ward	
Ward 1	35
Ward 2	23
Ward 3	3
Ward 4	19
Ward 5	28
Ward 6	34
Ward 7	39
Ward 8	52

Source: NeighborhoodInfo DC, from Census 2000 Long Form

Children Younger Than Age Three Experiencing Multiple Risk Factors

Number of Risks	0	1-2	3+
District of Columbia	32%	41%	22%
National	57%	33%	10%

Source: National Center for Children in Poverty, using the American Community Survey, 2005

Research demonstrates that circumstances characterized by multiple, interrelated risk factors impose particularly serious developmental burdens during the early childhood years and are the most likely to incur substantial costs in the future.[6]

Risk factors include any combination of the following: (1) single parent, (2) living in poverty, (3) parents do not speak English well, (4) parents have less than a high school education, or (5) parents have no paid employment.

Recommendations to Meet Goal I:
Improve Access to Health and Mental Health Services

Children develop best when they are healthy. Hunger, a vision or hearing impairment, or maternal depression can inhibit early childhood development, but each of these crises can be resolved with early identification and access to appropriate services. The American Academy of Pediatrics recommends healthy children visit the doctor ten times before their second birthday. In the District of Columbia, the health care system is a vital point of contact between child development professionals and parents with young children. These encounters are essential opportunities to identify and address developmental delays when they first begin.

Policy Recommendations

1. Increase prenatal care, with a focus on Health Professional Shortage Areas. Healthy development begins long before a baby is born. Prenatal care can improve birth outcomes, and District women continue to enter prenatal care in the first trimester at a rate lower than the national average.

A. ***Identify and address barriers to prenatal care.*** Barriers to prenatal care are complex, but worthy of additional resources and attention because of the significant impact prenatal care has on birth outcomes and the subsequent development of the child. In general, the leading causes of death for infants are birth defects, premature birth disorders, and sudden infant death syndrome. However, in the District, most infant deaths are due to maternal complications in pregnancy and delivery, which can be prevented with adequate and quality prenatal care.[18] The D.C. Department of Health Title V Block Grant Five-Year

KEY FACTS

- The District has one of the highest rates for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) health screens in the country, and exceeds the federal benchmark of 80 percent. In 2005, 86 percent of children ages 1-2 on Medicaid received at least one EPSDT health screening or well-check.[7]
- In 2004-05, 13 percent of children younger than age 18 were uninsured and 45 percent were on Medicaid. Nationally, 20 percent are uninsured and 26 percent are on Medicaid. Pregnant women, children, and parents earning up to 200 percent of the federal poverty level are eligible for Medicaid.
- According to the D.C. Behavioral Risk Fact Surveillance System for 2002, less than 10 percent of adult women in the District lack health insurance, yet more than one-third (36 percent) reported they did not seek preventative care.[9]
- More than one-third of mothers in the District do not begin prenatal care in their first trimester and do not have at least nine subsequent visits. The rate increases to almost half of all pregnant women in Wards 7 and 8.[10]
- In 2002, Medicaid paid for 64 percent of births to District residents.[11]
- Eleven percent of infants born in the District

Needs Assessment (1998-2003) indicates women do not seek earlier care because they do not know they are pregnant, are unable to get a prenatal appointment early in their pregnancy, or do not have enough money or insurance to pay for prenatal care. Task force members heard stories of women becoming impatient with long visits in waiting rooms to spend five minutes with a doctor, and stories of health facilities that are poor quality. More time, attention, and funding are necessary to understand and remove the barriers to prenatal care. The District can look to the D.C. Developing Families Center as a model for providing prenatal care. Approximately 30 percent of its clients travel from Wards 7 and 8 to receive care at its Birthing Center in Ward 5.

B. ***Improve the quality and number of prenatal care facilities in Health Professional Shortage Areas.*** Making high-quality prenatal care easily accessible is one way to improve access to prenatal care. Forty-seven percent of women of childbearing age, infants, and children live in federally designated primary medical care health professional shortage areas (HPSA),

Providing prenatal care: The Birthing Center (District of Columbia)

According to Linda Randolph, executive director of the D.C. Developing Families Center, health care professionals must recognize that prenatal visits require time to build supportive relationships with the patient, and health insurance companies must provide adequate reimbursement for longer visits. The Birthing Center is implementing the CenteringPregnancy® Program, an evidence-based model where women are invited to join a support group that meets after they receive their usual obstetric care. The same group meets every month and through the initial postpartum period, forming a support network for the expectant parents and allowing a skilled facilitator/practitioner to observe and interact with the individuals in the group. For more information, www.centeringpregnancy.com.

are low birthweight (weighing in at less than 5.5 pounds). Seventy-five percent of these babies are non-Hispanic Black.[12]

- The infant mortality rate in the District increased to 11.8 deaths per 1,000 births in 2004. This is the highest rate since 2000.[13]
- Immunization rates in the District have increased steadily between 2000 and 2004, exceeding the national average since 2002. However, rates declined in 2005 from 98 percent to 94.4 percent of children vaccinated against the major childhood diseases.[14]
- The American Academy of Pediatric Dentistry encourages parents and other care providers to help every child establish a dental home by age one. Only 6 percent of children ages 1 and 2 who are on Medicaid received any dental services in 2005.[15]
- Between 1998 and 2003, the District's Medicaid fees remained the same for primary care and obstetric physicians, and declined by 2.4 percent overall. This was the largest decline among the states where, on average, fees increased by 27 percent.[16]
- Medicaid reimbursement rates in the District are among the lowest in the country. Nationally, Medicaid reimburses primary care physicians an average of 62 percent of Medicare fees. A Medicaid primary care physician in the District of Columbia receives 35 percent of the Medicare fee for the same service.[17]

and 30 percent live in medically underserved areas.[19] The census tracts that experience the highest numbers of adverse health indicators (i.e. infant mortality, low birthweight babies, and prenatal care) are highly correlated with health professional shortage areas.[20] There are at least two funding opportunities to expand prenatal care facilities in the District.

- $ The new mayor will have to act on the recommendations of the Health Care Task Force report delivered on August 1, 2006. That report recommends that a minimum of $212 million be invested in building health care facilities in the eastern part of the District of Columbia in the next few years. Access to prenatal care can be improved if these new facilities include prenatal care clinics and/or birthing centers.

- $ The D.C. Primary Care Association is distributing grants to build health care facilities that provide a medical home for District residents, with priority going to Wards 7 and 8. Access to prenatal care can be improved if child care centers, or other places women may go on a daily basis, partner with health care providers to submit applications to build facilities that are convenient and inviting.

2. Support current efforts to improve the developmental screening of children, and increase efforts to ensure children receive the followup evaluations and services they need. Children's developmental needs change as they grow. Risks and delays are identified earlier when children have regular access to a primary care medical home. The DC Partnership to Improve Children's Healthcare Quality (DC PICHQ) is a collaboration between local pediatric providers and the D.C. Medical Assistance Administration to improve well-child health care delivery and documentation. The result is the implementation of standardized medical record forms (SMRFs), which will increase the likelihood that children receive comprehensive health exams, at regular intervals, using the best guidance about how to promote their physical, emotional, and behavioral health. The forms reflect the best practice standards of care recommended in the American Academy of Pediatrics and Bright Futures guidelines. Data from visits to the primary health care provider will be captured in a new Child Health Data Registry. Although the data will provide a more accurate picture of the health and developmental needs of D.C.'s children, they will not guarantee that individual children receive appropriate followup evaluations and/or interventions in a timely fashion.

A. ***Provide core funding for the DC Partnership to Improve Children's Healthcare Quality to continue implementing, validating, and continuously improving the standardized medical record forms.*** Currently, the DC PICHQ relies on a small grant from the Commonwealth Fund and a subcontract with the Medicaid managed care plans to implement the SMRF utilization citywide. This funding is insufficient to further validate and refine this valuable tool to improve provider effectiveness in identifying medically- and developmentally-at-risk children. Additional funding would allow DC PICHQ to revise the standardized form to

enhance its effectiveness in identifying at-risk children, and provide ongoing feedback and training for pediatricians to improve their screening. More funding would also allow DC PICHQ to conduct a pilot survey to see how many children identified through the standardized reporting process actually received comprehensive developmental evaluations and recommended services.

B. ***Increase Medicaid reimbursement rates so children receive the followup evaluations and services they need.*** Improved screening is just the first step. The DC PICHQ's initiative will provide data about the need, but will not *fill* the need. Better identification of at-risk children will necessarily generate additional demand for developmental specialists for comprehensive evaluation and appropriate treatment, and developmental specialists are already in short supply. Increasing the Medicaid reimbursement rates for both primary care screening and developmental specialty evaluation is critical to ensuring that children get the services they need.

3 • Help parents bridge the gap between their children's health care needs and the health care system. Task force members heard story after story of parents who could not get appointments for their children and ended up in emergency rooms. Child care providers spoke of parents who did not know when to seek the advice of health care professionals, and parents who did not know how to advocate for their children when seeking advice. Doctors spoke of children aging out of the early intervention (birth through age two) program before they received needed services. Infants and toddlers cannot get to the doctor without the help of their parents, and the anecdotal evidence suggests that these adults need more help in knowing when and how to access health care.

A. ***Examine how Medicaid managed care organizations are conducting outreach to parents.*** A portion of the administrative costs that Medicaid managed care plans receive is specifically designated for outreach to parents, with the goal of getting those parents to bring their children to the doctor for regular check-ups. The task force recommends the Medical Assistance Administration review the guidance on the use of these funds and

Identifying social and emotional delays: Assuring Better Child Health and Development II

The Commonwealth Fund and the National Academy for State Health Policy launched the second phase of their Assuring Better Child Health and Development (ABCD II) initiative in 2004. Although the final evaluation results will not be available until 2007, preliminary data suggest the five grantee states have successfully improved the care of young children with, or at-risk of, social or emotional developmental delays. Although grantee states chose various means by which to achieve the same goals, all five states relied upon developing standardized screening guidelines, increasing the use of screening to identify delays, educating physicians on integrating screening guidelines into their practices, and improving referrals to necessary services. By creating such guidelines, as well as a database of local and state resources, the five states improved the ability of clinicians to identify problems early and direct those patients to available services, thereby filling service gaps that prevent children from receiving supports they need. For more information, http://www.cmwf.org.

evaluate the effectiveness of the outreach efforts. A more targeted, coordinated approach to parent education and outreach could help parents be better advocates not only for the health of their children, but for their own health as well. This effort can be coordinated with the recommendations in the next section to support families of very young children.

B. ***Support the recommendation of the District of Columbia's Children with Special Health Care Needs Advisory Board to create a central service delivery system to provide early identification, diagnosis, and treatment.*** This system would be central, interdisciplinary, comprehensive, culturally competent, coordinated, family-centered, and modeled after the former Children with Special Health Care Needs Clinic located on the grounds of D.C. General before it was closed in 2001.

C. ***Raise awareness about the importance of a dental home.*** Oral health is just as important as general health, and encompasses more than just healthy teeth. The American Academy of Pediatric Dentistry (AAPD) recognizes that early prevention practices reduce the risk of preventable oral disease that can significantly impact learning. In 2006, AAPD recommended all parents establish a dental home for their children by age one. In 2005 in the District of Columbia, only 6 percent of all children ages one or two who receive Medicaid received any dental services.[21] By raising oral health awareness, the prevention, early detection, and treatment of dental disease can be integrated into health care policies to ensure young children are physically healthy and ready to learn. Collaboration between early intervention programs, early care and education programs, physicians, and dentists will help ensure public awareness of age-specific oral health issues and the impact on learning.

4. Ensure access to mental health services by increasing the organizational commitment and resources of the Department of Mental Health in regard to early childhood development. Infants develop in the context of relationships and are highly sensitive to the quality of care they receive from their primary caregivers. Because the parent-child relationship is so important for early development, the mental wellness of adults plays a critical role in how young children develop.[22] Parental depression can negatively affect children if parents are not capable of providing consistent, sensitive care, emotional nurturance, protection, and the stimulation that young children need.[23] Parental mental health problems can also have a biological impact on the development of a child by raising the level of cortisol in the brain, which has been linked with internalizing problems, extreme behavioral inhibition, social wariness, withdrawal, and increased anxiety disorders.[24] Because the incidence of maternal depression is high (and even higher for families in poverty),[25] too many young children are at risk for developing mental health and behavioral problems such as infant depression, attachment disorders, and aggression. As a result, intensive and targeted mental health services for young children and their families are necessary.

A. ***Appoint an individual in the District's Department of Mental Health to focus solely on early childhood mental health, particularly working to address the mental health needs of very young children.*** The District of Columbia Department of Mental Health has a Director of Children's Services, but no one who focuses specifically on the mental health needs of young children. This recommendation would assign a separate individual to develop a plan for how to address the mental health needs of very young children in the District by addressing three strategies representing a continuum of services: 1) promotion services aimed at maintaining the social and emotional well-being for all young children; 2) prevention services targeted toward children who are at risk of mental health disorders; and 3) treatment services that provide individualized attention to young children and families already exhibiting symptoms of mental health disturbances.[26] This plan could be informed by the District of Columbia Early Childhood Mental Health Planning Committee, and the success of states participating in The Commonwealth Fund's Assuring Better Child Health and Development II initiative (see sidebar).

B. ***Garner funding to reinstate access to mental health consultation for all early childhood programs.*** Infants and toddlers are spending more time in nonfamilial care, so child care providers, home visitors, and Early Head Start staff must have appropriate skills to promote the children's social and emotional development. Mental health consultation in child care is a proven and effective model for preventing behavioral problems and reducing expulsion in child care, supporting relationships with families, and identifying early warning signs of mental health disorders. The District had an early childhood mental health consultant project, but funding ended in 2006. This project placed graduate psychology students in early childhood classrooms, supervised by a licensed mental health professional. These consultants provided support to teachers when children displayed challenging behaviors and other social-emotional issues. They also provided occasional direct services to children and their parents. San Francisco pioneered a promising model for mental health consultation in child care that is a replicable best practice.

Providing mental health consultation in child care: Early Childhood Mental Health Program (San Francisco, California)

The Early Childhood Mental Health Program is a collaboration of the Jewish Family and Children's Services, Day Care Consultants of the University of California at San Francisco, and several county and community mental health agencies. With an end goal of improving the overall quality of child care and healthy childhood development, the project relies upon skilled consultants to provide onsite support to 65 child care centers serving low-income, at-risk children (from birth to age five) in the Bay Area. Each consultant works directly with child care professionals in a particular facility to improve the overall quality of the program. In addition, they provide case consultation for individual children by assessing a child's needs; developing guidance, training, and mentoring for teachers; and suggesting appropriate interventions and support to the staff. Consultants also help design parent support and education activities. Funding of the $1.5 million program comes from TANF and the Child Care Development Fund. Those children requiring additional services receive assistance through Medicaid. For more information, www.jfcs.org/Services/Children,_Youth,_and_Families/Parents_Place/Early_Childhood_Mental_Health_Consultation/default.asp

Recommendations to Meet Goal II:
Support Families of Very Young Children

The task force recognizes the importance of alleviating poverty for the overall well-being of children. Although this report does not provide specific recommendations to improve the economic security families need to adequately care for their young children, the task force strongly recommends that the District's new mayor makes this issue a priority – for families with children of all ages, but particularly for those with infants and toddlers.

Young children thrive in stable, nurturing families. They learn and develop in the context of family, and their early development depends on the health and well-being of their parents.[27] Parents must be able to successfully face the challenge of caring for their children while, at the same time, meeting their work and other responsibilities. Children and families living in poverty face even greater challenges, and are more likely to experience school failure, learning disabilities, behavioral problems, mental retardation, developmental delays, and health impairments.[28] Research indicates that the risks posed by poverty are greatest among children who experience poverty when they are young, and among children who experience persistent and deep poverty.[29] With close to one-half of the infants and toddlers in the District living in low-income families, and almost one-quarter living in extreme poverty (below 50 percent of the federal poverty level or $8,300 for a family of three),[30] the need to provide additional supports to families is obvious.

At one time or another, most families turn to early childhood development professionals for support and guidance. For some families, a conversation with a nurse or a child care provider will be the support they need. For others, more intense and specialized services are necessary, such as mental health or child welfare services. The District of Columbia can support parents of very young children by ensuring easy access to information about the importance of their job as a parent, and clearly identifying where they can turn for help.

Policy Recommendations

5 • **Intensify efforts to provide parenting information and support to parents of newborns, infants, and toddlers.** Parents need adequate time and resources to carry out their parenting responsibilities, and they need to know how and where to seek professional help when necessary. Public media campaigns and telephone information/referral services have the potential to provide reliable assistance and advice for families with young children,[38] but the quality and availability of these services in the District is inadequate.

A. ***Ensure help lines provide responsive assistance and accurate referral information.*** The District of Columbia has multiple telephone information and referral services, but they are not well advertised and the information they have available is often out-of-date. Improving both the quality of the information and the training of the individuals who answer the phone is the first step in providing responsive and accurate assistance.

- ***Convene administrators of the District's primary help lines for parents of very young children to establish a schedule for regularly updating information.*** Those include the Parent Directory, Access HelpLine, 1-800-MOM-BABY, the Mayor's Call Center, and 211 Answers, Please! Many of the parenting information services in the District rely on the *Parenting Education Directory*, which was last updated in 2002. Data available at the online information centers at www.dc.gov can be

three and four years old. Information and referral services are only as good as the information they provide. Establishing a regularly scheduled meeting for the administrators of the various referral lines in the District will enable staff to keep current on services and be accountable for regularly updating information.

- ***Improve training for staff who answer these help lines to ensure appropriate and responsive assistance.*** In a national study of help lines, most states report they provide at least some training to staff answering calls. However, only 21 percent of states require training that can certify staffers as information and referral specialists, and fewer than 10 percent of referral lines have a child development specialist answering calls.[39] Training might include basic information on early childhood development and information on new community resources and services for young children and their parents.

B. ***Launch an outreach campaign for parents, particularly fathers, to raise awareness of the importance of the first three years of child development and to***

KEY FACTS

- Seven Healthy Families Thriving Communities Collaboratives work to provide a seamless network of community partners focused on building strong families and supportive communities in which children, youth, and adults can thrive. Although local needs drive the focus of the collaboratives, their work includes primary prevention efforts to keep children out of the foster care system. Between 1999 and 2005, the number of children in foster care declined from 3,466 to 2,554.[31]

- Since 2004, the District of Columbia Fatherhood Initiative (DCFI) has helped 3,000 low-income fathers overcome barriers to providing emotional and financial support to their children. In October 2006, the District received a $10 million Responsible Fatherhood Program federal grant to expand the work of the DCFI over the next five years. The District is one of only two jurisdictions in the nation to be awarded this grant, which requires funding activities to promote healthy marriage, responsible parenting, and economic stability.[32]

- The overall number of families applying for emergency shelter in the District decreased for the first time in six years, but the proportion of families with children younger than age five increased. In 2005, 2,936 families applied for emergency shelter – down from 3,326 in 2004. But 37 percent of the families with children included a child who was five years old or younger. This is an increase from 35 percent in 2004.[33] Funding for the Housing Production Trust Fund, which supports the construction and renovation of affordable housing in the District, has doubled from $68 million in 2006 to $132 million in 2007.[34]

- Fifty-six percent of all births in the District were to single mothers, and in Wards 7 and 8 the rate is 80 percent or more.[35]

- More than half (52 percent) of all grandparents in the District are directly responsible for the care of their grandchildren – approximately one-third of them live below the poverty level.[36]

- There are an estimated 2,000 at-risk families in the District who could benefit from home visiting services, and less than 30 percent receive them.[37]

connect them to existing information and referral resources. Once the infrastructure is in place to provide parents with accurate and responsive assistance, an outreach campaign can inform parents about these resources. In addition to raising awareness about available resources and help lines, such an outreach campaign can promote effective parenting practices. For example, radio, television, and print ads can explain the importance of prenatal care or having a medical and dental home, and then refer parents to a help line for more information. Given the high percentage of single mothers in the District, a special effort can be made to reach fathers. The outreach campaign should reflect the latest research on social marketing to ensure messages are culturally appropriate for the diverse populations in the District, and effective with the target audience – parents. Public outreach campaigns can be expensive, but there are several existing campaigns that the District can modify, such as the Born Learning campaign.

6. **Expand and better coordinate home visiting services to families.** Home visiting can be an effective way to reach vulnerable infants and toddlers before delays occur, thereby preventing more long-term costs associated with remediation later on. Home visiting is a unique approach as it reaches families where they live, eliminating many of the scheduling, employment, and transportation barriers that might otherwise prevent them from accessing community services.[40] Generally, programs combine health care, parenting education, child abuse prevention, and early intervention services. Although the research has shown mixed results, evaluations of some home visiting programs demonstrate that they can improve parenting skills, foster increased parental self-confidence, and help lay the foundation for children's later success in school.[41] The benefits of home visitation vary across families and programs.

A. ***Provide core funding for the Home Visiting Council to coordinate existing home visiting programs, provide training and evaluation so programs meet high standards of quality, and ensure families receive appropriate home visiting services.*** Like most cities, the District of Columbia has multiple home visiting programs, and the list is still growing. The replication of the Parent Child Home program will join DC Healthy Families, Healthy Start, HIPPY, Early Head Start, Parents as Teachers, and several other programs that can potentially target the same families. The Home Visiting Council was created in 2000 to strengthen the quality and improve the coordination of home visiting programs throughout the District. The Council effectively convened

Creating an effective public outreach campaign: Born Learning

Born Learning is a $37 million national campaign built in partnership with the United Way, Civitas, the Families and Work Institute, and the Ad Council. With 350 local and state Born Learning campaigns around the nation, the focus is on helping parents, grandparents, caregivers, and communities create positive early learning opportunities for young children. Utilizing public service announcements and advertisements as well as educational resources on its website, the Born Learning campaign provides tips to caregivers on ways in which to encourage learning, fact sheets on a child's ages and stages, and helpful parenting checklists. In addition, the campaign offers strategies for community action and public policy advocacy. State and local Born Learning campaigns vary from increasing parent outreach and education to engaging hospitals, pediatricians, state agencies, and the business community to encourage these groups to be part of its program. For more information, www.bornlearning.org.

local home visiting programs – who then jointly established standards for best practices in home visiting – and then developed training to support programs in meeting those standards. The small grants and in-kind contributions that Council members relied on in the startup phase cannot sustain the work of the Council over time. With core funding of $50,000 per year, the Council can coordinate high-quality home visiting programs and maximize the number of families who receive services.

B. ***Increase funding for home visiting services.*** A high-quality home visiting program costs a fraction of the cost of foster care and other expensive services available to families only after they fail. An estimated 2,000 at-risk families in the District could benefit from home visiting services, but less than 30 percent of these families participate.[42] Targeted, high-quality home visiting programs can be a cost-effective strategy to improve health outcomes, parenting skills, and educational outcomes for families.

C. ***Establish a universal screening and referral process for all District residents who are parents of newborns.*** A universal assessment and referral process in the District will ensure that the families who receive home visiting services are those who most need support, and that families are referred to the home visiting program that best meets their needs. The D.C. Department of Health is currently piloting universal screening for home visits at Providence, Howard, and Washington Hospital Center. Data from this pilot can inform the expansion of a universal screening process until it is available to all District residents.

7. Dedicate local funds to provide early intervention services to more infants and toddlers. Part C of the Individuals with Disabilities Education Act (IDEA) requires all states to define who is eligible for interventions that address developmental delays of children from birth to age three, screen children in order to identify who should receive services, and provide appropriate services to those who are eligible. The federal law allows states to define eligibility, but sets a benchmark of serving a minimum of 2 percent of all children younger than age three. Federal funds are capped, so most states must supplement Part C funds to meet the needs of children identified as eligible for early intervention services.

According to the IDEA Infant and Toddler Coordinators Association, the District of Columbia is one of only a few states that do not dedicate any state or local funds for early intervention (IDEA Part C) services. The percentage of children served in the District is also among the lowest in the country, although it is improving. In 2004, the District served 1.3 percent of all children younger than age three, and in 2005 the percentage rose to 1.68 percent.[43] The District may not meet the federal 2 percent benchmark because it has one of the most restrictive eligibility definitions. The District requires at least a 50 percent delay in one or more aspects of development, while other states are much more inclusive. In fact, six states include children who are not yet developmentally delayed but who have biological or environmental factors that are predictive of delay.[44] By dedicating local funds for early intervention services, the District can expand its definition of eligibility to include more children who are experiencing developmental delays and who can benefit from services that will minimize those delays.

Recommendations to Meet Goal III:
Promote Positive Early Learning Experiences

Babies are born learning. Learning happens through play, the active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. Babies learn in the context of relationships, through everyday routines and experiences. The quality of these early experiences matters. High-quality early learning experiences are associated with outcomes indicative of later school success, like early competence in language and cognitive development, cooperation with adults, and the ability to initiate and sustain positive exchanges with peers.

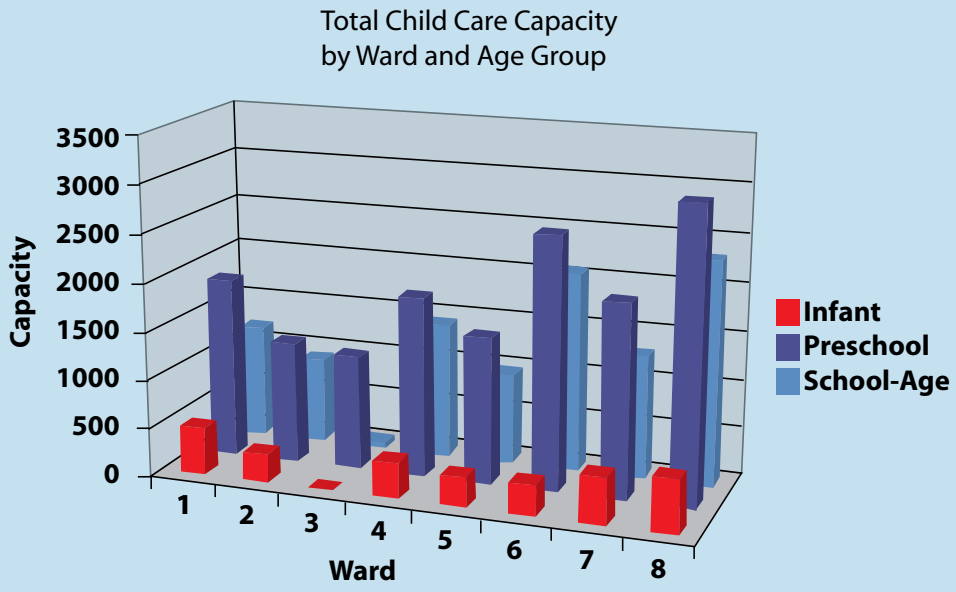
Research indicates that high-quality early care experiences make a difference for very young children; however, access to quality programs is uneven and inadequate in the District, especially for infants and toddlers. The following recommendations aim to improve the overall quality of care, and to coordinate high-quality services to meet the comprehensive needs of families with infants and toddlers.

Policy Recommendations

8. **Create a network of early development programs, and at least two comprehensive service centers, particularly in neighborhoods with poor performing schools and high concentrations of poverty.** Three decades of research shows that when early childhood programs focus on both child development and family development, opportunities for optimal child and family development can be realized even for the most vulnerable.[56] Comprehensive early childhood programs such as Early Head Start mitigate the effects of poverty by providing basic supports through early, high-quality, comprehensive, continuous services. The National Evaluation of Early Head Start showed that comprehensive services such as nutritional meals and health care, education and job training for parents, and child development and parenting classes have a positive impact on families. When compared to families who did not receive Early Head Start, children had more positive interactions with their parents and made great advances in cognitive and language development. Parents also showed they were more emotionally supportive and provided significantly more support for language and learning.[57] A network of Early Development Programs like Early Head Start would help improve quality and bring comprehensive services to child care settings serving infants and toddlers in the District.

A. ***Develop a network of Early Development Programs building on existing child care providers.*** The District needs more high-quality child care programs that address the comprehensive needs of families. Child care centers are the "new neighborhood" where families interact on a daily basis with others who care for their children. As the model of the DC Developing Families Center demonstrates, child care centers can be the hub for the comprehensive services that families need – from child care to health care to other family supports. The District can

KEY FACTS



Source: DHS/Office of Information Systems
Online OECD Childcare System - Provider information database, 2006.

- The District has one of the highest access rates for children eligible for child care subsidies. Sixty-eight percent of eligible children received subsidies in 2005-06, while the national average is estimated to be between 15 percent and 20 percent.[45]

- The District has the highest percentage of accredited family child care homes in the nation and the third highest percentage of licensed child care centers with national accreditation.[46] However, access to accredited child care is uneven, especially for children who depend on child care subsidies. Overall, 45 percent of preschool children are in accredited child care centers that accept child care subsidies, but only 38 percent of infants and toddlers are in accredited centers. In Ward 8, 30 percent of infants and toddlers and 47 percent of preschool children are in accredited centers.[47]

- Of the 1,243 providers with Child Development Associate (CDA) credentials that work in the District, 589 have an Infant/Toddler specialization.[48]

- Seventy percent of *all* four-year-olds in the District are enrolled in a Head Start or prekindergarten program.[49]

- Only 4 percent of infants and toddlers (from birth to age three) in families earning at or below the federal poverty level receive Early Head Start services, compared with 66 percent of eligible three- and four-year-olds who receive Head Start services.[50]

- Of the 348 licensed child care centers in the District, only 149 offer infant care. These centers have the capacity to serve 3,893 children younger than age two, yet there are an estimated 14,000 children younger than age two in the District. By comparison, 325 of the 348 centers serve children from age three to age five,[51] with a capacity to serve more than 15,000 preschool children.[52]

- The percentage of infants and toddlers in high-quality child care centers varies greatly by Ward, from only 16 percent in accredited centers in Ward 5 to 100 percent in accredited centers in Ward 3. [53]

- Child care data gathered over a four-year period indicate the quality of child care in many infant/toddler classrooms in the District is inadequate.[54] The Quality Training Assessment Project (QTAP) found that out of twenty-four indicators, almost half were rated "minimal" or "below minimal" for all four years.[55]

raise the level of quality in existing child care settings by funding access to the comprehensive supports and services that families need (see sidebar on Characteristics of High-Quality Early Development Programs). The District can look to Rhode Island and Oklahoma as examples of how to promote a network of high-quality early development programs.

B. ***Create at least two comprehensive service centers in areas of the city with high concentrations of poverty.*** In areas of the Distrct where services are scarce (i.e., Wards 7 and 8), facilities should be built that will provide services under one roof. These comprehensive service centers, modeled after DC Developing Families Center or Educare (see sidebars), would provide direct services to children and families. These centers would also serve as a focal point for health, mental health, and family support outreach to family child care providers and family, friend, and neighbor (FFN) caregivers. The District should seek private funds to help build the facilities. In addition, there are at least two other potential funding opportunities:

- The CareBuilders Recoverable Grant Program offers financing and free technical assistance to new and existing child care providers seeking to create, expand, or improve child care services for infants and toddlers. The grants can be used to cover costs associated with making physical changes to new or existing child care sites that will result in the creation, expansion, or improvement of child care services for infants and toddlers.

- The D.C. Primary Care Association distributes grants to build health care facilities that provide a medical home for District residents. Wards 7 and 8 are given priority.

9. Support the professional development of infant and toddler child care providers. Research confirms that quality child care is contingent upon the special training that caregivers receive in early childhood development.[59] Both formal education levels and recent specialized training in child development have been consistently associated with high-quality interactions and children's development.[60] In the District of Columbia, infant and toddler caregivers need more education and training focused specifically on the unique needs of children younger than age three. These caregivers need credit-bearing opportunities and training, as well as on-the-job mentoring and support.

A. ***Support a career pathway that leads to degrees and/or credentials for infant and toddler caregivers.***

- ***Establish an Associate of Arts (A.A.) degree in Child Development with a concentration in infant and toddler care at a local institution of higher education.*** Across the country, states are developing specialized degree programs and training opportunities specifically for infant and toddler caregivers. Seventeen states now either have, or are in the process of establishing, an infant/toddler credential that recognizes training, coursework,

and experience in working with infants and toddlers in child care programs. These states are increasing the availability of coursework and training, and formally recognizing the completion of this education with a credential, certification, or endorsement. At the University of the District of Columbia, past proposals to establish an associates degree in child development with a concentration in infant and toddler care have failed. The new mayor can support a future proposal to the Department of Education and the College of Arts and Sciences with the University of the District of Columbia, as well as encourage other District institutions of higher education to offer a similar degree.

- ***Increase child care subsidy reimbursement rates to support base pay at the living wage level for caregivers in subsidized programs.*** Like parents, caregivers cannot give focused attention to the children they care for if they are distracted by financial insecurity. The D.C. Living Wage Act of 2006 requires recipients of new contracts or government assistance to pay affiliated employees and subcontractors who perform services under the contracts no less than the current living wage of $11.75 per hour.[61] The law exempts most child care workers, who earn an average wage of $8.96.[62] Including subsidized child care providers under the Living Wage Act will help programs attract and retain qualified providers.

- ***Increase scholarships for infant and toddler caregivers to earn credentials.*** A significant body of research in child care settings links well-trained, qualified teachers and staff to better child outcomes, particularly for low-income children who are at-risk for early developmental problems and later educational underachievement.[63] With the help of additional scholarships that cover costs associated with higher education (e.g. tuition, books, travel), more infant and toddler caregivers in the District can have the opportunity to take college courses leading to two- or four-year degrees in child development or early childhood education.

- ***Promote increased staff compensation linked to professional development and education.*** Child care programs have difficulty attracting and retaining well-trained individuals to work with young children, in part, because they do not pay a "living wage." In the District of Columbia, the average child care worker earns $8.96 per hour, and the average preschool teacher earns $11.96.[65] Adequate compensation is critical to ensuring the stability of a well-trained, qualified early childhood workforce. Compensation or retention initiatives for child care providers often link increases in a child care professional's compensation to increases in his or her qualifications.[66] By compensating child care providers for receiving additional training and education, the District can retain child care providers and work to improve the quality of the child care workforce. North Carolina employed such a strategy and saw a reduction in the turnover of child care providers.[64]

Early Development Programs

Characteristics of High-Quality Early Development Programs[58]

- The program is accredited or has received the highest quality rating
- Master teachers have a B.A. degree (or equivalent) with a focus on infant development
- Teachers have a Child Development Associate (CDA) with infant and toddler specialization, and are working toward an A.A. degree (or equivalent)
- Teachers' assistants/aides have, or are working toward, a CDA
- Teachers receive training in early learning and development guidelines for children from birth through age three
- Children receive continuity of care
- The program takes a family strengthening approach
- The program supports developmental screening and followup
- The program has connections to a school or preschool in the neighborhood
- There are linkages to health and mental health supports
- There is a hub of support for parents, family, friends, and neighbors

Promoting a network of high-quality early development programs:

Comprehensive Child Care Services Program (Rhode Island)

Rhode Island has been at the forefront of early care and education services, becoming the only state with an entitlement to child care assistance for low-income families as well as access to health care coverage for child care staff. Under the umbrella of its Starting RIght initiative, the state has also taken a unique approach to expanding Head Start services to low-income preschoolers through the Comprehensive Child Care Services Program (CCCSP). CCCSP funds networks of child care providers in the provision of comprehensive services based on those offered under the federal Head Start program (early education and child development services; social services; health, mental health, and nutrition services; parental involvement activities; and school readiness services). Not only do the networks of providers need to meet essentially the same standards as the Head Start Program Performance Standards, but they also must establish a policy council that determines how to spend funds. In addition, the networks must support home visiting for all participants. The CCCSP networks spent $1.3 million in 2004, providing services to nearly 300 low-income preschoolers. For more information, www.dhs.state.ri.us/dhs/famchild/CCCSP.pdf.

Pilot Early Childhood Program (Oklahoma)

The Oklahoma state legislature appropriated funds to the state Department of Education to fund a pilot early childhood program. Applicants must serve infants and toddlers from families with incomes at 100 percent of the federal poverty level or less. To ensure that programs receiving funding provide high-quality early learning experiences that are developmentally appropriate for young children, grantees who participate in the pilot have to meet Early Head Start standards, and have to begin the process for accreditation by the National Association for the Education of Young Children (NAEYC). Furthermore, there must be one teacher with a bachelor's degree in every two classrooms; all assistant teachers must have an associate's degree; and all teachers' aides must have a CDA. Most of the programs that will receive funds initially are Early Head Start programs, because they are already in compliance with the majority of the standards, but officials are reaching out to the child care and early learning community to participate in this pilot.

Providing comprehensive services under one roof:

Developing Families Center (District of Columbia)

Funded through the private, public, and business communities, the DC Developing Families Center is a unique model of collaboration that offers uninterrupted care for women and their families during the childbearing and early child-rearing years. All services are provided under one roof in a center that is easily accessible to low-income communities of Carver Terrace and Trinidad/Ivy City in northeast Washington. Services include: health checkups for women, children, and teens; pregnancy testing; early childhood development services; immunizations; prenatal care and education; a free-standing, homelike birth center; job training; social service assistance; and continuing education. For more information, http://www.developingfamilies.org/FAQs.html.

Educare (Omaha, NE)

Modeled on the Educare program originally established by the Ounce of Prevention Fund in Chicago, Educare of Omaha provides full-day, year-round education and care to 239 low-income infants, toddlers, and preschool-aged children. Included in this group are children with special needs, English language learners, and children whose parents are enrolled in school, job training, or work at least part-time.

Funded through a public-private partnership with state agencies, Omaha public schools, Head Start, Early Head Start, and sliding scale participant fees, the program is built around promoting kindergarten readiness. By working closely with the Omaha school district since it began in 2002, Educare's teachers regularly attend trainings with district teachers and collaborate on curriculum standards. In addition, the program emphasizes low child-staff ratios, parent volunteers, monthly parent informational meetings, and family partnership agreements to identify goals for a child's success. As part of its daily program, Educare focuses on language and literacy, social skill development, music, and art. It also provides a nutrition and health program, offering regular physical and dental exams as well as periodic health screenings. For more information, www.educareomaha.com/index.asp.

Policy Recommendations to Meet Goal III

B. ***Provide training on the birth-to-three early learning guidelines through the Early Childhood Leadership Institute.*** Early learning guidelines are research-based, measurable expectations about what children should know (understand) and do (competencies and skills) in different domains of learning.[67] Currently, eighteen states have adopted early learning guidelines for children from birth to age three. The Early Childhood Leadership Institute at the University of the District of Columbia is in the process of developing similar guidelines for the District, which

should be completed by the end of 2006. In order for the guidelines to be effective, infant and toddler caregivers must be trained on both what the guidelines say and how to integrate them into their daily work. An effective implementation plan will include onsite observation and instruction to ensure that providers integrate the guidelines into the care setting.

C. ***Develop a network of infant/toddler specialists who provide onsite guidance and support to infant and toddler caregivers on issues related to early development, health, mental health, family support, and program quality.*** In addition to education and training opportunities, providers need experts to come into their child care centers or homes, effectively providing on-the-job support and training to improve the quality of care. Training would be specific to issues affecting infants and toddlers, including integrating the District's soon-to-be-released birth-to-three early learning guidelines (recommendation 9-B) and improving infant mental health (recommendation 4-B). Infant/toddler specialists typically include health, mental health, and family support professionals. Specialists work with providers using a variety of approaches, including mentoring, coaching, consultation, training, technical assistance, and referral. Seventeen states have developed networks of infant/toddler specialists – most are funded through the federal Child Care and Development Fund. In the District, the network could also include curriculum and assessment professionals to ensure the content of the programs meets the forthcoming early learning standards for children from birth to age three.

D. ***Increase the capacity of child care settings to provide care to families that reflects their culture and language.*** As states and communities become more diverse, child care providers face the challenge of ensuring that care is culturally appropriate. Research indicates that all early childhood policies and programs should be designed and implemented within a culturally sensitive context and in a manner that respects the importance of individual differences among children and families.[68] Early childhood caregivers need to understand the role that culture plays in a child's development and respect families' cultural beliefs and traditions. The District can look to Minnesota as a model of how to increase the capacity of child care providers to implement culturally appropriate best practices.

Supporting cultural differences: Family, Friend, and Neighbor Best Practices Project (Minnesota)

With nearly one-half of all families relying on family, friend, and neighbor (FFN) child care, Minnesota has launched a new initiative to meet the needs of the state's increasingly diverse population. By studying the best practices of families from among the Hmong, Latino, African-American, and Native American communities, the FFN Best Practices Project works to ensure all children are fully ready for kindergarten regardless of cultural differences. The results of these studies provide resources to FFN caregivers and increase the ability of early education professionals and caregivers to implement the most culturally appropriate strategies for entry into formal schooling. For more information, http://www.ready4k.org/index.asp?Type=B_BASIC&SEC=%7BC2C1E3F7-E149-484C-AE5E-

Recommendations to Meet Goal IV:
Provide the Resources and Support Necessary to Ensure That

To help ensure that all infants and toddlers have access to quality early childhood programs, states need to be strategic and creative in how they finance services and supports for very young children and their families. In tight fiscal climates, federal, state, and community policymakers are challenged to find, allocate, and effectively use funds for early childhood programs.[69] Funding needs to come from private and public sources – parents, employers, civic groups, government (federal and state), and foundations.[70] States are using a variety of approaches to help finance services for infants and toddlers, from creating public-private partnership funds to establishing a set-aside for babies in their preschool programs.

Policy Recommendations

10. Ensure that funding is available to implement these recommendations.

A. ***Establish a set-aside of at least 20 percent of any preschool expansion funds to improve infant and toddler care.*** Access to high-quality prekindergarten programs lays the foundation for later school success. However, learning begins even before birth, with a healthy pregnancy, and continues past the first day of kindergarten. Formally linking the growth of funding for the District's prekindergarten and infant/toddler programs recognizes that important and lasting development takes place during the first three years of life. The federal government established this linkage with a 10 percent set-aside of Head Start funds for Early Head Start. Illinois replicated this model and created the infant-toddler set-aside of the Illinois Early Childhood Block Grant.

B. ***Increase child care funds targeted at improving infant and toddler care.*** Access to quality programs in the District of Columbia is uneven, especially for infants and toddlers. According to the Quality Training Assessment Project, the quality of child care in many infant/toddler classrooms in the District is inadequate.[71] Between October 2002 and August 2006, classroom assessments were

Establishing a set-aside:
Early Childhood Block Grant (Illinois)

Illinois has set an example for other states and communities by taking steps to bridge the gap between infant-toddler initiatives and other preschool initiatives through the creation of the Early Childhood Block Grant and the Infant-Toddler Set-Aside. In the mid-1990s, a push occurred to consolidate programs and funding for early childhood. Advocates used this effort as an opportunity to link prekindergarten to infants and toddlers – borrowing the precedent established by the federal government with Early Head Start, which is funded through a set-aside in the Head Start appropriation. In 1997, the Illinois Early Childhood Block Grant became law, and funding for infants and toddlers was defined as 8 percent of the block grant. The rapid increase in funding for child care and prekindergarten since 1997 led to funding increases from $3 million to $30 million for infants and toddlers. The set-aside for infants and toddlers is now 11 percent of the Early Childhood Block Grant. The Illinois General Assembly recently passed legislation that requires all Block Grant programs serving infants and toddlers to use a research-based program model. For more information,www.ounceofprevention.org/downloads/publications/Infant_Toddler_setaside.pdf.

Children Get Off to a Good Start

conducted in 119 child care centers (325 total classroom observations, including 123 infant and toddler classroom assessments). The evaluation found that out of 24 indicators, almost half were rated "minimal" or "below minimal" for all four years.[72] Many of the areas where the District's infant and toddler classrooms performed the worst were health-related – factors that predict overall child care quality – such as meals and snacks, nap, and diapering and toileting. The findings are based on average scores across classrooms.

The percentage of infants and toddlers in accredited centers varies greatly by Ward; from only 16 percent in accredited centers in Ward 5 to 100 percent in accredited centers in Ward 3. In addition, the demand for infant care in the District far exceeds the supply. There are 7,500 children born annually in the District but only 4,210 licensed slots (including center-based and in-home child care providers) for children younger than age two. Additional funds for infant and toddler care can address the issues of poor quality and inadequate supply documented in the aforementioned recommendations.

C. ***Expand Early Head Start funds or encourage Congress to permit Head Start funds to be used for children from birth to age five in the District of Columbia.*** Although Early Head Start is a federal-to-local program, in recent years, states have joined with Early Head Start to expand and enhance services for infants, toddlers and their families. States may use state funds to expand programs (as with the Kansas Early Head Start program highlighted

Expanding access with state funds: Early Head Start (Kansas)

Beginning in 1998, the governor of Kansas and the state legislature authorized the first-ever state expansion of the federal Early Head Start (EHS) program, using funds transferred from the state's Temporary Assistance for Needy Families (TANF) block grant and the Child Care and Development Block Grant (CCDBG). Under this expansion, the Kansas Early Head Start model provides the same comprehensive services as the federal program, utilizing weekly home visits as well as visits to center-based and family-based child care facilities.

Three aspects of the Kansas program make it unique. First, it requires its sites to partner with existing child care providers rather than provide child care services directly. Secondly, it seeks to expand the availability of its full-day, year-round care by covering three-year-olds who fall through the gaps between qualifying for EHS and Head Start. Lastly, it allocates funds to provide professional development training and technical assistance through a partnership with the federal Department of Health and Human Services and the Administration for Children and Families for Region VII. Because the Kansas EHS program must follow federal Head Start Performance Standards, these funds are particularly useful, as Kansas EHS staff and child care providers must obtain a Child Development Associate credential within one year of hire.

From its inception in 1998 with just four sites, the Kansas EHS program has expanded to 13 sites in 32 counties, directly serving 825 children, including approximately 300 three-year-olds. In addition, approximately 150 child care providers in those counties serve an additional 2,000 children who benefit from receiving services from a child care setting that is required to meet the federal Head Start Performance Standards. For more information, www.srskansas.org/ISD/ees/childcare_ehshs.htm.

in the sidebar) to serve more infants and toddlers. States and communities are increasingly providing services to preschoolers, providing more options for children eligible for Head Start to participate in other preschool programs. In the District of Columbia, approximately 70 percent of all four-year-olds are in Head Start or public prekindergarten, yet only 4 percent of eligible children (from birth to age three) receive Early Head Start services. The District can encourage Congress to allow Head Start grantees in every state to reallocate resources to services for infants and toddlers through the reauthorization of Head Start. In the meantime, the new mayor can seek permission from the federal government to pilot the conversion of Head Start funds to Early Head Start services. The District is in a unique situation, as it does not have the same geographic flexibility as states to move Head Start funds from low-need to high-need areas. The District should not be penalized for increasing local funding for three- and four-year-olds by losing Head Start funds.

Building public-private partnerships: Early Childhood Education Endowment (Nebraska)

In 2006, Nebraska created an Early Childhood Education Endowment to fund quality services for at-risk children from birth to age three statewide. The endowment is a public-private partnership that will annually generate $2 million in interest from the $40 million public Educational Lands and Trust Funds, and $1 million in interest from a $20 million endowment funded by private entities. Grants will be awarded to school districts and educational service units to partner with local agencies or programs in their communities for services for these children. Grants will be competitive and will require a match of at least 50 percent of the total program costs. For more information, www.nde.state.ne.us/ECH/RFP%20Endowment/Overview.pdf

D. ***Create a public-private partnership dedicated to funding services for infants and toddlers.*** Public-private partnerships help engage stakeholders to support and help fund early childhood programs. Several states have created new types of funding mechanisms, called public-private partnership funds, to support early childhood programs. A public-private partnership fund could be established as an endowment fund that distributes the interest or a limited percentage of the fund's value to programs that serve children younger than age three. To avoid duplication and competition, the establishment of the public-private partnership should be coordinated with the existing District of Columbia Early Childhood Collaborative at the Community Foundation for the National Capital Region. The District can look to Nebraska as a model.

11. Ensure adequate personnel in city government to support programs and services for children and families. Severe staffing shortages due to vacant positions make it difficult for local government agencies to manage programs that serve young children. Currently, it can take more than two years to fill vacant positions. Although this problem is far from unique to human services agencies, it is extensive. Programs cannot provide needed services with chronic staffing shortages.

Conclusion

The first three years of life are crucial in a child's social, emotional, and cognitive development. At no other time in a child's life will he or she experience such unparalleled growth. As such, the District of Columbia has a critical responsibility to take action to support early childhood development now.

Although the depth and breadth of the recommendations reaffirm there is no single or simple solution, three principles should guide future decisions about prioritizing and implementing these recommendations.

Support the development of strong families and nurturing caregivers. The healthy development of young children depends on the healthy development of the adults in their lives. Families that face economic insecurity, parents who struggle with substance abuse or mental illness, and child care providers who do not have adequate skills or resources cannot provide the nurturing environments that babies and toddlers need to thrive.

Provide comprehensive supports. Families with babies and toddlers need access to a medical and dental home, high-quality comprehensive child care, home visiting services, and mental health, substance abuse, and other family support services. These families need coordinated access to all of these supports, not a piecemeal approach, to protect them from the multiple risks threatening their healthy development.

Target areas of extreme need. There are concentrated areas of extreme poverty and risk in the District of Columbia. Babies, toddlers, and their caregivers who live in these areas have the most to lose from our inaction, and the most to gain from a coordinated, comprehensive response.

Encouraging the new mayor and city leaders to enact policies that support good health, strong families, and positive early learning experiences for all infants and toddlers living in the District is of paramount importance. Simply put, the District's infants and toddlers need our intervention today – their future depends on immediate action.

There is no time to wait.

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